Owensboro Health

December 8, 2014

Emily Whelan-Parento
Executive Director
Cabinet for Health and Family Services
Office of Health Policy
275 East Main Street, 4W-E
Frankfort, KY 40621

Re: Certificate of Need Modernization

Dear Ms. Parento,

Thank you for the opportunity to comment on the Office of Health Policy's Certificate of Need Modernization effort. The following comments are on behalf of Owensboro Health Regional Hospital (OHRH), a 477-bed tertiary care facility in Daviess County, Kentucky. OHRH is recognized by the Medicare program as a sole community hospital and a rural referral center, providing all tertiary care services except Level III NICU (for which it has just received approval), burns and transplants. We emphasize that these comments are not submitted in connection with any particular agenda of OHRH, but in the hope they will provide needed insight about the relationship between certificate of need and some of the critical functions of non-profit, community-based hospitals like OHRH.

We think our experience in Owensboro, coupled with my own experience as an analyst in managed care, strategic planning and reimbursement for the West Penn Allegheny Health System in Pittsburgh during the period of repeal of certificate of need, provide some important and often overlooked perspectives on the issue of certificate of need and deregulation. This letter is intended as a companion to provide more complete textual explanation of the slide presentation that we presented to you, Eric Friedlander and Diona Mullins on November 24, which we would like to incorporate by reference.

OHRH Success Story: Consolidation vs. Cooperation

The story of OHRH demonstrates how the current CON environment has enabled the goals of high-quality and cost-efficient care. Owensboro has a population of approximately 58,500, and Daviess County a population of 100,000. Before 1995, Owensboro had two non-profit hospitals, which were fierce competitors. In 1995 these two hospitals merged and consolidated their services at the site of the former Owensboro Daviess County Hospital. With the merger, OHRH adopted as its mission "to health the sick and improve the health of the community we serve."

In order to satisfy federal antitrust laws, the new hospital was required to have the financial effects of the merger analyzed and certified by an outside firm (KPMG in Chicago). The immediate effects of the merger included savings of $25 million in capital renovations that would have had to be performed at the campus of the old Mercy Hospital, which was

demolished instead. After the merger, the new organization reduced charge rates four times, which according to KMPG saved the community $243 million in cumulative charges through 2000. The KMPG report also showed that the merged organization achieved operational cost savings of $128 million as a result of the merger. We think this is a powerful testament to the benefits of cooperation and consolidation, as opposed to competition, among health care providers.

OHRH is now the largest employer in the community with 3400 full-time employees, including 129 physicians and mid-level practitioners. While Daviess County is OHRH's primary service area, its secondary service area includes 13 counties in Kentucky and Southern Indiana, many of which have no hospital or only have a small, critical-access hospital with minimal services.

In 2003, OHRH's Board of Directors established quality of care as a system-wide imperative, and the organization has fully committed to making investments necessary to improve quality and safety. The results of this effort so far have been outstanding, although we still have work to do. We have received many awards from the national Healthgrades organization, which measures hospitals' achievement of specific statistical benchmarks. Among these is our inclusion as one of America's 100 Best Hospitals in 2013 and 2014.

In 2011, OHRH joined 11 other hospitals in a five-state region in the "Target Zero" initiative sponsored by VHA Inc.'s Central Region and Healthcare Performance Improvement, LLC, to eliminate serious, preventable patient safety errors and move toward zero defects in patient care. This initiative involves a multi-faceted approach to building a culture of safety throughout the organization. During this period OHRH has demonstrated remarkable improvements in its standardized mortality rates and its occurrence of safety events.

OHRH is one of two sites in the state participating in the CMS Community-based Care Transitions Program, which began two years ago and works with multiple providers and payors to improve coordination of post-hospital care and reduce readmissions for three specific conditions: heart failure; acute myocardial infarction and pneumonia. This results of this effort so far have been extraordinary: OHRH is the top hospital in the country in pneumonia readmission rates, with a low of 13.6%, is in the 99th percentile for heart failure readmissions, and 83rd percentile for AMI readmissions.

At the same time OHRH has embodied this commitment to reaching new levels in quality of care, its financial performance reflects excellent stewardship of the community's health care resources. Its charges for services are measured at .92 compared to a national average index of 1.0,[1] and are significantly lower than other area referral centers, Vanderbilt University and larger, Louisville-based systems. It is in the 62nd percentile nationally (with 100th percentile being the best, or lowest, cost) for direct cost per case and in the top quartile of the CMS calculation of spending per beneficiary. We also routinely analyze whether the rates we quote to employers and commercial insurance plans are competitive, and our data indicate that they are.

Hospital Financial Health Supports Unprofitable Services

As a non-profit organization and a sole community hospital with a pervasive mission to improve the health of the community, OHRH is committed to providing unprofitable services that are needed by the community. These services include obstetrics (which are no longer available at many of the small community hospitals in OHRH's secondary service area, because of the cost), psychiatric and chemical dependency care, and, through employment of physicians, subsidization of physician specialties that would otherwise be financially unsustainable. Inpatient care overall is not profitable due to the high overhead and low or negative margins for large portions of our patient base, including expanded Medicaid, and maintenance of an emergency room and all the associated resources – for example, 24/7 lab, MRI, surgeons on call, the ability to assemble a large cardiac response team on a moment's notice – all add costs that are not fully compensated through the payments received for the patients that depend on them.

OHRH's commitment to its mission is also reflected in its charity care statistics. In 2014, it provided $34.4 million in charity care. Before the 1995 merger, the level of charity care was $4.5 million. Its ability to reach these levels can be attributed in part to the fact that resources are not being squandered on duplicative capital investments made to fight competition. In addition, it also makes direct expenditures on community health initiatives; the $2.5 million it spent in 2011 was about the same as its nearest competitors, St. Mary's and Deaconess in Evansville, *combined.*

Regulatory and Evolutionary Challenges: All Hands On Deck

Of course, OHRH's organizational focus on making quantum leaps on quality and being good financial stewards is not occurring in a vacuum. At both the state and federal level, new regulatory initiatives and methods of paying for care are effecting enormous changes

[1] This data is from Cleverley and Associates, which measures hospital charge rates and scores them using a proprietary charge index that permits comparison of a hospital's overall charge level to other hospitals in the country on an apples-to-apples basis.

and competing for the attention of hospital executives as well as consuming additional resources.

Kentucky's 2011 conversion to Medicaid managed care is an example. The substitution of, at first, three new managed care organizations, and then a total of five MCOs to manage Medicaid beneficiaries' care, means that providers have six Medicaid payors whose policies have to be learned and navigated just to get paid. This means more business office personnel. Particularly because some of these MCOs have implemented systems that appear to have the sole purpose of making it impossible for providers to be paid, the transition has meant, for the most part, that hospitals have to spend more money in order to be paid even less than they were being paid under traditional Medicaid.

And while Medicaid expansion holds some promise of getting paid for patients who previously would have received charity care, there are other effects of the Affordable Care Act that we do not yet know but are trying to anticipate and plan for. These include a substantial volume of patients, some of whom had insurance before, who now have insurance that was purchased under the exchange, but whose policies have high deductibles, often with *no first-dollar coverage* that they are cannot meet the out-of-pocket requirements and will forego receiving care unless the provider can find a legal way to work with them.

Meanwhile, hospitals throughout the country are spending millions of dollars on new electronic medical records systems in order to avoid being penalized in their Medicare payments. In addition to being very expensive, these transitions are painful and require prodigious amounts of attention at every level of the organization to plan, develop, educate and implement.

At the same time hospitals like OHRH are dealing with new regulatory imperatives, they are also, as a practical matter, the focal point for initiating the innovations in care delivery that the Affordable Care Act promotes and that are likely to be necessary to achieve long-term control over health care costs. OHRH is working to transform the delivery system across outpatient and inpatient settings so that care is provided seamlessly. In most cases, these innovations do not earn separate reimbursement, but they represent investments in better health care for the future. In addition, OHRH has just been approved by CMS to establish an Accountable Care Organization, and like many other providers is continually exploring ways to promote wellness in the community, and improve access to care.

In sum, stewardship of a community health system like OHRH increasingly demands a constant, all- hands-on-deck balancing of the demands of many inter-related constituencies – including the state and federal governments, private insurers, employers in their communities, Medicaid managed care organizations and, most importantly, their patients. With ever-increasing regulation and ever-decreasing payments, managing the delicate

balance of satisfying all these needs, cost-effectively, while not just maintaining quality but improving it, becomes more complex and challenging every day.

CON Considerations

Particularly when considered against the backdrop of a non-profit community-based hospital that is earnestly trying to meet the needs of all these constituencies, any de-regulation that would divert attention to new competitive concerns, or further threaten the already-narrow margins in which we work, will be damaging.

A. Riverview Surgery Center. We have an excellent recent example of the potential harm that could be caused by deregulation in Riverview Surgery Center, a physician-owned ambulatory surgery center opened in 2012 just across the river in Rockport, Indiana. The physicians who own Riverview have diverted approximately 3000 surgeries per year that they would otherwise have performed at community-owned facilities like OHRH or the freestanding Owensboro Surgery Center. However, this is not simple, arm's-length competition, by design, and the financial effects are not limited just to other provider facilities. The physician owners control where their patients choose to have procedures done, and there are no controls on what they tell patients. We are aware of numerous instances in which patients have been told false information about the services available from OHRH by a physician who owned an interest in Riverview and wanted to do his surgery there. Riverview does not provide charity care, has not in the past taken Medicare or Medicaid, and does not participate in any commercial plans since that would require it to price its services competitively. Instead, its pattern has been to accept only patients with commercial insurance that can be manipulated to pay exorbitant prices.

   Here is how it works: Whenever a provider treats a patient as an out-of-network provider, it usually is with the understanding that the commercial plan will pay a certain percentage of their charges, and the patient will be responsible for the remainder. Riverview games this system by setting charges that are four or more times the amount of charges at other providers, and then collecting the bare minimum of cost-sharing from the patient. The result is payment from the commercial insurer – most often an employer – that even after the out-of-network discount from charges is three or four times the amount that insurer would have paid to another facility. Exhibit A hereto is a chart comparing charges, facility payments and patient payments for ear tube placement surgery; these are recent data from my own experience as a payor for services to OHRH employees as well as a parent of a child who recently received these services at NKC in Louisville. Ear tube surgery is a ten-minute procedure - for which Riverview charges $13,500 and is paid $7000! The cumulative effect of these practices on employers in OHRH's service area is approximately *$15 million per year.* Unfortunately, employers who

pay for these services are not sophisticated enough to protect themselves against this financial shakedown.

OHRH believes that the effect of deregulation on employers and employer-sponsored health plans is an extremely serious economic concern that is often overlooked in conversations about regulation or de-regulation of healthcare providers. Among other issues, access to quality, affordable health care is an extremely important factor to companies who are deciding where to open offices and plants.

B. The Pennsylvania Experience

Pennsylvania's certificate of need program was eliminated in 1998. In the ensuing years, multiple statistics indicate that it has been destabilizing and harmful for the health care delivery system. Before the sunset, hospital operating margins generally exceeded two percent. They dropped for several years afterward, including a year of negative average margins in 1999. Uncompensated care as a percentage of gross patient revenue dropped from 4.69% in 1997 to 2.15 % in 2004 and 2013 in 2.81%. (In the same period, OHRH's percentages went from 6.29% to 6.37% and 7.32%).

- In 2004, there were 182 general acute care hospitals in Pennsylvania. 120 of these hospitals, or 66%, had a 3-year negative average total margin at some point during FY 1998 through FY 2004. Twenty percent of the 120 merged or affiliated with another health system in the state (e.g. AHERF and West Penn).

- Seven hospitals have closed during this timeframe, including a large safety-net tertiary care system, St. Francis Health System in Pittsburgh, in 2002. Prior to its closing it had 2,350 employees.

- Twenty-one hospitals converted to for-profit status from 1999-2005.

- A 2011 Study showed that Pennsylvania is one of 14 states that do not oversee medical spending, and is among the top 10 in borrowing for hospital construction in the four years from 2007-2011.

- In 2012, the $240 Million UPMC East opened less than a mile from Forbes Regional Hospital. Forbes is a 349-bed facility with 15,000 inpatient admissions, 12,000 surgeries, nearly 50,000 emergency department visits annually, and a level II trauma center. It has been a community safety net hospital since its opening in 1978. I would compare this to having a new, 150-bed hospital opening next to OHRH. This particular straw prompted some legislators to push to bring back certificate of need.

Wage Index. Following the sunset of CON, Pittsburgh area hospitals imposed wage freezes or reductions because of the need to divert resources to the capital arms race. This in turn meant that the area's wage index, as measured by CMS for purposes of adjusting Medicare payments to hospitals, decreased from 1.0 before CON sunset, to .85 now. The net result of this was a *loss of $50 million in annual federal payments.* While some increments of this could be made up over time, the lost ground as compared to other areas of the country likely can never be made up in total.

Quality Concerns. It has long been accepted that there is a strong correlation between volumes of open heart procedures and outcomes. The American College of Surgeons has a benchmark of 200 cases per year as the minimum for an open heart surgical team to be efficient and have quality outcomes. In Pennsylvania specifically, its Health Care Cost Containment Council found in 2003 that surgeons who performed 200 to 250 procedures had patients twice as likely to survive after bypass surgery as physicians who performed fewer than 100. In short, volume matters.

The sunset of CON in Pennsylvania, however, harmed the goal of assuring that those providing heart surgery did enough procedures to maintain competence. In 1995, Pennsylvania had 43 hospitals that offered open heart procedures. The volume averaged 600 cases per center and average charges per case ranged from $27,500 to $106,000. By comparison, in 2003, Pennsylvania had 63 hospitals that offered open heart procedures. The volume averaged 390 cases (with the lowest center completing only 98 cases), and average charges per case ranged from $39,000 to $369,000. There were 65 physicians who performed open heart procedures but performed fewer than 100 in 2003, and 17 hospital programs with fewer than the benchmark of 200 cases.

OHRH's Sole Community Hospital Status

As with the wage index issue noted in Pennsylvania, there are other Medicare payment factors of which state regulators should be aware. OHRH is one of eight hospitals in the state that are recognized by Medicare as "sole community hospitals," which collectively receive an additional $50 million in enhanced federal payments each year to assure the availability of needed services. This status depends on being located a certain distance from other hospitals (not including specialty and critical access hospitals). Any regulatory decision that inadvertently jeopardized this status for any of these hospitals could result in a substantial loss of federal funds – funds that are paid out to employees locally for goods and services - and endanger the programs that these funds are designed to secure.

Conclusion

Sea changes are taking place in every facet of health care delivery and payment today – as a result of the Affordable Care Act, Medicaid managed care, other initiatives of CMS, transition to electronic medical records, transition to ICD-10 coding, provider and payor

consolidation, employer mandates and insurance strategies. Adapting to all of the externally-generated changes while trying to find new and better ways to deliver care and save health care dollars takes every bit of time, attention and money that a system like OHRH can devote, and even then there are not enough hours in the day. The health care system as a whole has not yet seen the full effects of the Affordable Care Act, and when those become more clear, unintended secondary effects are sure to follow.

Many providers like OHRH are doing their part to drive helpful innovations in service delivery, cost containment and community health. This is due in part to legal mandates, but also because providers realize that effective management of the health of their patient populations is the key to their futures. Changing the certificate of need laws in the pursuit of any objective that is not well-defined, or the consequences of which are not well-understood, could sabotage their efforts to drive these positive changes at a time when we already have all the challenges we can handle.

OHRH believes that all of the foregoing considerations require extreme caution by the Office of Health Policy before implementing any significant change in the competitive landscape of health care. Our own experience demonstrates that there are already in place ample incentives and opportunities for all of the constituencies of our health care system to emphasize quality, reduce costs, implement technology and advance the other goals that are being discussed in the context of modernization. Modernization can happen, and is happening, today under the laws that are in effect today.

On the other hand, well-intentioned and apparently beneficial legal changes can have disastrous unforeseen consequences that cannot be remedied simply by trying to change things back. As noted above, some of the effects of CON repeal in Pennsylvania are not likely to ever be undone. While we understand and applaud the mindset of any official whose goal is to make things better, in this area experimentation just for the sake of doing something can be far more dangerous than beneficial. Especially in the current environment, it is far better as a policy approach to err on the side of maintaining the status quo in the area of certificate of need.

Of course this conversation is in large part about the financial health of providers like Kentucky's many non-profit hospitals, whose ability to invest in unprofitable services, provide charity care, invest in their communities and pay good wages to their employees will be directly affected by any efforts to de-regulate. However, it is also about employers and private insurers, who pay for the vast majority of health care in this state. The decisions this office makes affects what they pay for health care services and even whether or not a new business will come to Kentucky at all. And of course, the decisions ultimately affect the citizens of this state and affect whether or not they will have access to quality, affordable health care.

Health care is more and more complicated every day. The pot is already boiling. Throwing additional changes into the mix, in the form of significant changes to Certificate of Need laws that have heretofore provided some measure of stability for providers like OHRH, has enormous potential to do more harm than good. We urge the Certificate of Need Office to proceed with the greatest caution.

As noted above, OHRH has no particular projects on the table and no agenda to prosecute other than assuring wise policy choices that help it achieve its charitable mission. We will be glad to assist you or offer additional insights at any time you mind find it to be useful in your deliberations.

Sincerely,

Russ Ranallo
Vice President, Financial Services

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Owensboro Health

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